PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

4/2/2026

Prior Authorization

Internal Use Only

JOHNS HOPKINS HEALTH PLANS

Anzupgo - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Anzupgo - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Anzupgo (delgocitinib)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Will the requested medication be used for any indications that are not Food and Drug Administration (FDA)-approved or guideline-supported? Y N

[If yes, no further questions.]

2.	Will the requested medication be used concurrently with other janus kinase (JAK) inhibitors or potent immunosuppressants?	Y N
	[If yes, no further questions.]	
3.	Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	Y N
	NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.	
	[If no, skip to question 5.]	
4.	Has documentation been provided showing patient has achieved or maintained a positive clinical response as evidenced by improvement [e.g., improvement in or resolution of any of the following signs and symptoms: erythema (redness), edema (swelling), xerosis (dry skin), erosions, excoriations (evidence of scratching), oozing and crusting, lichenification (epidermal thickening), OR pruritus (itching)]?	Y N
	NOTE: Submission of medical records is required.	
	[No further questions.]	
5.	Does the patient have a documented diagnosis of moderate to severe chronic hand eczema (CHE)?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
6.	Has documentation been provided showing hand eczema has been present for more than 3 months or has resolved and returned at least twice within the past 12 months?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
7.	Has documentation been provided showing patient has had a trial and failure with both of the following: A) One or more medium or higher potency topical corticosteroids AND B) One topical calcineurin inhibitor [ex. Elidel (pimecrolimus) or Protopic (tacrolimus)]?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
8.	Is the patient 18 years of age or older?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date